UNDERSTANDING THE SIGNIFICANCE OF EYE TROUBLES.

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listener, the worker should be familiar with the different types of cancer and the implications of their treatment. When her client tells her that he cannot bear the thought of going through life with a colostomy, she should know that this involves a loss of bowel control which may be a real threat to him. It is also helpful to know the various types of appliances that are available to reduce the discomfort occasioned by a colostomy. When the client's feelings center about the fear of facial disfigurement, she should have some idea of the extent to which this may be expected and the possibilities for plastic repair. The skilled worker will be able to recognize when the patient really needs factual information and reassurance and when his fears are related to more underlying and basic needs.

ALTHOUGH the social worker's greatest contribution in the field of cancer will be the service she is able to render to the individual cancer patient, there are numerous other ways in which her influence will be felt. She may not only be the means of helping her own client to arrive at an acceptance of the disease but her thoughtful and understanding interpretation of cancer to his family and the community will go far in helping the general public develop a more wholesome attitude. The numerous opportunities which present themselves to her for interpretation of the need for adequate treatment, the importance of continuous and uninterrupted medical supervision and observation over a long period of time, and the hopeful aspects of early treatment make the social worker a most effective channel of cancer education. The medical profession will be directly aided by the more intelligent co-operation of the cancer patient and his increased ability to persevere throughout the life-long period of observation so essential for an adequate evaluation of the results of treatment. Social workers need to look at cancer with a greater awareness of their part in the control of the disease that threatens the security and happiness of mankind.

Understanding the Significance of Eye Troubles

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TO understand the necessity for a trained eye worker in any hospital or dispensary, one must stop to consider the appallingly small number of doctors in comparison to the number of patients. The lack of time the doctor has to give to each patient is only equalled by the lack of privacy. When one realizes that it is not an uncommon occurrence for a doctor to see from twenty to forty patients in a morning clinic, it is no wonder that he has not time to explain to each patient the nature of his eye condition, the necessity for repeated visits to clinic, and the urgency of following out certain recommendations. It is upon the eye social worker that this burden falls, and hers is a three-fold task:

(1) She must interpret to the patient the significance of the diagnosis and the importance of treatment. This is necessary in some instances because of the patient's inability to grasp recommendations, in others because of a language difficulty. Interpretation must likewise be made to the doctor of the patient's attitude toward his eye condition, the financial difficulties that hinder his following the treatment, the emotional barriers that make clinic attendance a horror to him. Interpretation to the community is possible through the worker's contacts with other organizations interested indirectly in the prevention of blindness, such as clubs, schools, fraternal organizations and other social agencies. The social worker's rôle as interpreter cannot be over-stressed. At a time like this when we are just emerging from the throes of a depression, and particularly in the south where so many thousands of families are dependent, it is inevitable that a large percentage of the patients attending free clinics should be clients of some relief-giving agency. The special eye worker would indeed be swamped if she could not fall back on non-medical social agencies, both public and private, to assist her in solving some of her problems of relief, diet, and clinic attendance. Without the aid of the

family case worker, the medical social worker would be powerless in many instances.

(2) The second task of the special eye worker is medical follow-up. It does not suffice to tell a patient once that he should report regularly to the clinic if he is to conserve his vision. He needs to be told this repeatedly, and constant reminders—through home visits, telephone calls, and letters—are necessary.

(3) The third and most important function of the eye social worker is case work. This implies handling a multitude of problems. It means getting financial assistance for needed diets; money for transportation to and from the hospital; funds for medicine and glasses. It implies explanation and interpretation to the patient and frequently to the entire family of the diagnosis and prognosis of the illness. It includes having several or all members of a family examined as possible contacts. It always presupposes sympathy for the patient and personal interest in his welfare.

IN doing general medical social work and, later, in working with eye patients only, it has struck me forcibly that of no other ailment of the body are patients so absolutely ignorant. Patients seize the significance of tuberculosis, the tragedy of cancer, and the slavery of diabetes; but they fail to realize that eye conditions also are dependent on the general condition of the body. They persist in believing that drops and glasses are a "cure-all," and they insist that they have come to the eye clinic for one or the other. It takes a great deal of interpretation and persuasion to make them grasp the fact that nearly every eye disease is a local manifestation of some systemic disease and that the doctor cannot begin to treat eye conditions unless the teeth and sinuses are X-rayed, the tonsils are removed if diseased, the blood is tested, and a urinalysis is made. There is not a single eye diagnosis that does not need interpretation. Who is to give this if not the social worker? Certainly the doctor cannot stop to explain to a lay person the nature of a medical diagnosis. Such an explanation would take from ten to perhaps thirty minutes; the doctor has too many patients to see and these patients must be seen before clinic closes. Likewise, the doctor has not the time to explain the significance of the diagnosis to the social worker; in order to be a help to the doctor, the eye worker must be thoroughly acquainted with the various eye conditions, knowing especially the social implications each diagnosis presents. She must be equipped with as many sets of technics as there are diagnoses, for no two eye conditions present the same problems.

Starting with the new-born and following the life span of the patient to four-score and ten, the problems that confront the eye social worker are varied:

(1) *Ophthalmia Neonatorum:* In the new-born, this eye condition is known as "baby's sore eyes." It is a violent inflammation, caused by a germ contracted by the baby as it passes through the birth canal. It was formerly one of the greatest causes of blindness, but legislation and the concerted action of several groups have done much to prevent it. Six out of ten cases of ophthalmia neonatorum presuppose gonorrhea in the mother. If the baby has not been born in the hospital, the mother must have a vaginal smear made and the father must be examined as a possible source of infection to the mother. Besides hospitalization for the baby and clinic attendance for the parents until discharged, the elementary precautions in the home regarding the use of bed linens and toweling must be explained. Care must be exercised in interpreting to the baby's parents the nature of the disease—the husband is not to be accused of infecting his wife as this may lead to much unhappiness and domestic discord. It is easy to see what social problems lurk behind such a diagnosis.

(2) *Hereditary Eye Conditions:* By this we mean the myopic child, the child with congenital cataracts, the cross-eyed child, and those rare cases of retinitis pigmentosa. For the *high myope* or near-sighted child, follow-up for periodic examinations in clinic is instituted; activity limitation is outlined, excessive close work is prohibited; instructions as to correct posture are given; properly fitting lenses and placement in a sight saving class are prescribed by the doctors. The nature of the disease and its tendency to progress are explained to the patients or their families in order to gain their co-operation.

Even more interpretation is necessary for the child with *congenital cataracts.* This

condition invariably means a succession of operations, which the parents will invariably refuse; however, if the operations can be explained to the parents by telling them that each operation consists of a small incision in the lens and nothing more, their consent is often won. There is also the question of performing the operation for appearance' sake, explaining that, if the cataract is left un-operated, the child will have a gray pupil which is disfiguring. This generally touches the pride of the parents. The strongest argument, however, is to tell the parents that their child will lose the sight in the cataractous eye if the operation is not performed early. When consent has been secured and treatment instituted, there is still the necessity of contact with the family, so that the patient will return to the hospital for observation at stated intervals.

A nine-year-old boy from the country was seen in the eye clinic and a diagnosis of congenital cataracts of both eyes was made. His condition had been detected by his teacher and his inability to progress made his mother decide to take him to the hospital. This timid little mother, barely twenty-six years old, who did not understand a word of English and who had never left home before, was bewildered by the hospital; when the doctor told her that operations would have to be performed on her son's eyes, she immediately refused. She was on the point of deserting with the patient when the doctor referred her to the social service department. It was explained to her in her own language how necessary the operation was, the danger of not performing it being far greater than the risk incurred in the operation. Her consent was obtained, the first operation was successful, and the child is returning to the hospital for an operation on the other eye next month. A more co-operative mother would be difficult to find.

Cases of *strabismus* or "cross eyes" call for as much interpretation and persuasion. The old notions that glasses will straighten the eyes or that the patient will outgrow this condition still persist. In the beginning, there is no trouble making the patient wear his glasses from the moment he rises to the time he retires; it is after he has worn them a while and the eye still deviates that the social worker's rôle becomes difficult. Among the colored patients (and they are numerous), the belief is current that the doctor "takes out the child's eye to straighten it and puts it back." Careful discussion of what is done when a muscle is tucked is a help; and sometimes the argument that the operation should be performed for appearance' sake is of assistance. The most convincing argument, however, is to tell the parents that they are directly causing blindness through their neglect, and to stress the fact that it is an injustice to any child to allow him to go through life cross-eyed and partially blind.

A serious inherited condition and one which is responsible not only for very low vision but frequently for blindness, is *retinitis pigmentosa.* This is an inflammation of the lining of the eye found in patients in whose families there is a marked degree of consanguinity. In the eye clinic at Charity Hospital there have been three cases in a year and, in each, the patient's parents were closely related, though the fact was hard to establish and it was only through relatives and neighbors that we were able to prove it. Family histories on these cases have been helpful to the doctors.

A young Italian, twenty-five years old, recently lost his sight completely because of retinitis pigmentosa. A social history has revealed that the patient's mother is his father's own niece—in other words, that his grandparents are the same on both paternal and maternal sides. To this day, they refuse to acknowledge relationship and, still more tragic, our patient refuses to face the fact that he is blind. He will not hear of being taught any handicraft or Braille and will not have anyone assist him in any way.

(3) *Phlyctenular Keratitis:* One of the most common conditions found in patients between two and twelve years of age, and most frequently in debilitated children who react positively to a tuberculin test, is phlyctenular keratitis, an inflammation of the eyes due to the general condition of the body. Is the incidence of the disease on the increase due to the years of depression? It undoubtedly is, in patients who are clients of relief agencies, as the disease is a manifestation of the patient's general physical condition and diet and living conditions are paramount factors. Prevention is far more important than cure, as it has a tendency to recur. However, it is also the most hopeful of all eye conditions: time after time we have found that, as soon as the patient begins to get the right kind of food, the eye condition subsides. As a rule, we ask for a supplementary food budget to allow for extra milk, fresh fruit, vegetables, cod-liver oil, and a separate bed for the patient. The co-operation of a non-medical agency is absolutely necessary; without it, we cannot hope to aid the patient, for all local treatment will be of

no avail if diet and living conditions cannot be improved.

(4) *Syphilitic Eye Conditions:* The largest group of patients are those who are victims of syphilitic eye conditions. Interstitial keratitis, syphilitic iritis, and luetic optic atrophy are common diagnoses. They present a serious problem, for they not only necessitate treatment in the eye clinic until all inflammation has disappeared, but they demand treatment in the syphilis clinic for two years or more. In New Orleans, where we do not have a free night clinic for the treatment of syphilis, it is almost hopeless to try to combat the disease. When treatment interferes with work, and work means livelihood, we can hardly blame the patients who refuse to follow treatment.

The discouraging angle of the problem is that patients cease reporting for treatment as soon as all inflammation in the eyes has cleared. They believe themselves cured and it is only when the second eye becomes affected that they reluctantly return to clinic. Frankly, I have been most unsuccessful in impressing upon my patients that continuance of anti-luetic treatment is necessary and that a periodic check in eye clinic is equally important, if there are to be no recurrences of the disease.

It is an almost Herculean task to get every member of some of our large families to report to the clinic for Wassermann tests. Here the family welfare worker is of incalculable assistance, for she can reach the entire family during her visits in the home and can explain far better than the medical worker the danger to every member who takes the chance of going untreated. Although I do not have figures to substantiate my statement, I definitely feel that the greatest cause of blindness in Louisiana is syphilis. There is certainly no diagnosis which calls for more careful handling, more sympathy, more tact. An adolescent who learns that he has congenital syphilis is very apt to feel some bitterness toward one or both parents.

A young white woman, when she learned what was affecting her, immediately wrote a long and scathing letter to her father who had many years ago deserted her mother and ceased to provide for her and her sisters. She blamed him for her impending blindness, bitterly recalling his infidelities to her mother.

(5) *Glaucoma:* Glaucoma is a hardening of the eye due to increased pressure within it. What causes this pressure has never been determined. It is found most often in persons of middle age and can be acute or chronic. The glaucoma patients are the only group for whom Charity Hospital attempts 100 per cent follow-up. Unfortunately, the doctors in the eye clinic do not tell the patients that they have glaucoma, and no literature is given them explaining the nature of the disease and the necessity for close supervision. The interpretation and the follow-up, therefore, become the social worker's task. The chronic, non-congestive cases are the difficult ones to handle, for the patients slowly lose their sight, they suffer no accompanying pains in the progress of the disease, and therefore many of them report to clinic when it is too late.

The tragic feature of glaucoma is that whatever vision is lost during an attack is never regained and operations are performed to arrest blindness, not to restore sight. Many patients will not believe us when we try to explain the need for clinic attendance, and they continue to invent reasons for not reporting to clinic as fast as the worker makes these difficulties disappear. They are also loath to submit to an operation, and many of them desert from the hospital as soon as the operation is suggested.

As glaucoma always seriously affects vision, patients afflicted with it need the help of the social worker in getting work not requiring accurate vision. It may mean giving up work altogether and accepting relief; it always means less ability to sew and read; and it frequently means a complete change of environment.

We have had a seventy-six-year-old colored woman attending clinic for the last year and a half, losing her sight because of glaucoma. Tillie, our patient, and her husband, Edward, lived in a parish sixty miles distant from New Orleans. When Tillie's vision became "dim," Edward thought they should move to New Orleans to "be near the doctors," so he sold his small property and the few possessions he had—a cow and chickens—and moved to the city. Shortly after the change of residence Edward, who was nearly seventy-eight years old, became ill and could no longer work. The social service department secured aid for this couple from their parish and then old Edward died, leaving Tillie alone. We did not think it wise for Tillie to remain alone—her sight was so poor, and we had to make some plan whereby she could remain with relatives. If it had not been for the excellent co-operation of a society interested in the prevention of blindness and of a welfare agency, Tillie would have had to return to her home in the country in order to be given aid, and

she would have had to discontinue clinic treatment. Such cases as Tillie's are numerous.

(6) *Senile Cataracts:* Such a large per cent of senile cataract cases are known to social agencies that I should like to take them up at some length. Like chronic glaucoma, vision is dimmed gradually; but, unlike glaucoma, that vision which is lost can be regained through operation and, later, through properly fitting glasses. It is a common misconception that cataract, once it has made its appearance, inevitably leads to blindness, and that nothing can be done to check its progress or prevent its coming. It can be prevented through periodic health examinations, and it can be arrested by removing or treating any focal infection in the body, by treating the eye locally, and by saving the eye any undue strain. When operations are necessary, few patients refuse them as they are only too happy to think they have a chance of regaining their sight.

In a section of the country where relief is inadequate and the standard of living low, we find it a serious problem to secure glasses for our cataract cases. These patients will make every sacrifice to return to the hospital for as many operations as the doctors may see fit to perform, but when the prescription for glasses is given they invariably do not have the necessary funds. The chances of getting glasses for the aged are not as easy as for younger people where the argument of youth—they are going to school or are using their eyes for work—is always presented. The old man or woman has long finished his education and no work is available to him at his age. Unless the social worker can explain to the agency or the community that operations for cataracts are useless unless the patient is able to secure glasses, it is more than probable that the patient will never receive them.

Only a few of the most common diagnoses have been touched upon, but I should like to mention in passing some other eye conditions that need the services of a trained eye worker and the sympathy and help of a family case worker.

Toxic amblyopia, a progressive diminution of vision due to excessive use of alcohol and tobacco, calls for interpretation from the doctor, social worker, and family case worker. Not only does the necessity of refraining from intoxicating liquors and tobacco in order to prevent the progress of the disease demand explanation, but the patient needs help and advice to break a habit which has probably been life-long.

There are also cases of diabetic retinitis that necessitate reporting to eye and diabetic clinics. The family worker aids with the diet and the eye worker explains that if the diabetic condition is kept in check the eye condition will remain stationary.

Then there are the cases of sympathetic ophthalmia, so difficult to explain to parents, when it is necessary to remove an injured or diseased eye in order to protect the other; and those terrible and dramatic cases of intraocular tumor when the eye must be removed in order to protect life itself; there is no family that will receive this news without questioning.

OBVIOUSLY, it falls to the medical social worker to help the family case worker realize the significance of diagnoses made for patients attending eye clinic. The latter has not had the training the medical worker has and any diagnosis, no matter how simple, calls for interpretation. How much more so the eye diagnosis!

The family case worker must be made "eye conscious"—but she must first be told something about the eye before this consciousness can be aroused. Last year in New Orleans an interesting experiment was tried. The eye social worker of the School Board and the medical social worker in the Eye Clinic of Charity Hospital thought it would be a good plan to have a series of lectures on the eye and its diseases. Several ophthalmologists were asked to give lectures on the eye. The first was on the structure of the eye, and the doctor brought several specimens which he dissected, layer by layer. The listeners saw the conjunctiva, that thin skin covering the eye; they were shown the iris, the lens, and the three coats of the eye. When the lectures were finished, one of the doctors arranged for those attending to witness a series of operations: a muscle tucking in a cross-eyed young girl; the removal of cataracts from an aged man; several operations for glaucoma; and an enucleation. Among those present were social workers, Sight Saving Class teachers, the field worker for the Louisiana State School for the Blind, and several attendants from the eye clinics in

New Orleans. It was no trouble to get the doctors to lecture—all who were asked accepted and those who were not asked to speak requested that they be remembered the following year.

Another means of making the family case worker "eye conscious" is by having case conferences with agencies active on eye cases. These conferences afford an excellent opportunity to explain the nature of the eye disease, what has caused it, what will help it to improve, what will happen if directions are followed out, and what will be the result if these instructions are ignored. When case conferences are not possible because the patient is from out of town, the worker must rely on a letter to carry the message to the family case worker. A clear and detailed medical report giving the medical diagnosis and its explanation as well as the treatment to be followed at home has proved to be almost as beneficial as the conference.

The very essence of case work implies a striving for the entire good of the client. It does not mean merely the curing of his ailments and the adjustment of the family; if it does not encompass prevention of some kind, it is short-sighted. The social worker in the eye clinic must, as stated above, enlist the co-operation of the family welfare worker for, although the worker in an eye clinic can do a great deal toward the prevention of blindness, she cannot do it all. She does not see the client at home, nor does she visualize the difficulties that may hinder his returning to clinic. It is not given to her to see the family as a unit, and often she cannot explain to the patient's family the significance of the disease. Here the family case worker's aid must be enlisted. For instance, in the case of ophthalmia neonatorum, it is far easier for the family case worker to interpret the significance of the disease to the parents in the home than for the hospital worker who, perhaps, knows nothing of an impending marital discord. Then, too, the medical worker, because of the large number of patients in the eye clinic, does not always have the time to interpret to each individual in as detailed a way as she would like. The patient does not want to wait until clinic is over, when the worker would have the time to speak with him, for he is anxious to return home and is tired after waiting for his turn; however, if the family worker has understood the diagnosis she can interpret it to the patient in the privacy of his home. The family worker cannot afford to neglect a serious eye diagnosis when planning for the family. The head of the household who is threatened with blindness from glaucoma; the child who is out of school because of phlyctenular keratitis; the adolescent who loses his job because he has to report too often to clinic for treatment of interstitial keratitis—these situations cannot be overlooked, for they affect the entire family. Then, too, the psychological effect on the patient of impending blindness or a long and painful eye disease is to be considered. The family case worker cannot ignore the mental strain that will most assuredly result from these experiences.

Better results could be obtained if the worker in the eye clinic were able to have a conference with the family case worker on every eye case known to an agency. The medical social worker is too prone to send a follow-up letter to the patient and a cursory medical report to the agency and think that this mild type of urging and brief interpretation is going to bring the desired results. I do not mean to shift the burden of medical follow-up to the family case worker; but I do think that, if proper interpretation were given the family case worker at the very beginning of a patient's attendance at clinic, she could work hand in hand with the medical social worker. This type of team-work will undoubtedly result in both prevention and cure; however, there is apt to be a tendency on the part of the agencies, medical and non-medical, to carry on their case work as though they were working within walls. The family worker ignores the meaning of an eye diagnosis; the medical worker is not cognizant of the family difficulties. How can sound planning be achieved if a close relationship does not exist between the two agencies? If this ideal co-operation does not exist, I am convinced that it is because the medical worker has not made herself clear to the non-medical worker. To gain the best results she must enlist the interest of the family case worker, make her realize the significance of eye diagnoses, and show her

how valuable and even essential is her co-operation. The medical worker always has the excuse of the rush of work, or perhaps that the family worker has not shown sufficient interest. If the latter is so, then the fault is certainly the medical worker's. She should consider it her duty to make all the advances, as it were, by calling case conferences and by sending repeated, clear, letters. It is she who should go out of her way to interest the family worker. She can well afford to be the aggressor for she is, in reality, a salesman of medical information, and her aim is prevention of blindness.

I cannot think of any means by which better co-operation can be secured between the medical and non-medical agencies than the three I have outlined: lectures on the eye, case conferences, and intelligent medical reports. I am convinced that understanding team-work between agencies will make for a better handling of eye cases, for the specially trained eye worker cannot do all the work alone. To quote Miss Jane Hoey, Director, Bureau of Public Assistance, Social Security Board: "There should be a medical basis to social work just as there is a social basis to medical work—there cannot be a complete divorce of the two if the best results are to be achieved."

An Analysis of Two Interviews

Aase George

MR. MARTIN came to the family agency complaining of "nervousness" and asking if we could not send him to a "nerve doctor" so that he could become well enough to return to work as a draftsman.

Five months earlier he had been dismissed from his last place of employment after years of continuous service because his work had become too inaccurate to be used. There were marked symptoms of paresis and the results of the Wassermann test and lumbar puncture verified the psychiatrist's tentative diagnosis. His wife had partially completed nurse's training at a mental hospital prior to her marriage and from the beginning of our contact was aware of the seriousness of his symptoms. When we saw her, at Mr. Martin's suggestion, we found her frightened over the situation in which she discovered herself in middle life, eager to talk with us, yet extremely resistant. We gave her an opportunity to come in weekly on an appointment basis, thinking that perhaps we could be more helpful to her than to Mr. Martin—who ceased to seek us out once we had made contact for him at the clinic.

In the three interviews that preceded the two we are giving here as nearly as possible in verbatim form, Mrs. Martin had brought out a long history of behavior on Mr. Martin's part that had seemed strange to her, much fear regarding possible diagnoses, some feeling that the marriage had never been satisfying to her and that she now wished she had not been too easy-going to break away from Mr. Martin, and strong resistance to talking with us about these things and to accepting relief. Of particular interest, we thought, were Mrs. Martin's reactions in the two interviews immediately following her discovery that her husband was luetic, although her situation would never be duplicated and the treatment that seemed to help Mrs. Martin accept the fact of syphilis would therefore not necessarily prove helpful to another woman with a paretic husband.

The first interview we are quoting took place about an hour after Mr. Martin had come from the clinic and broken the news of the diagnosis to her:

Mrs. Martin at the office a little early for her appointment. As soon as she had been seated in our office, she asked in a strained voice, "What's the news?" We turned the question back to her. She evaded it, asking us directly what we had heard from the hospital. We said that we understood that the doctor was ready to make a diagnosis now.[1] Had Mr. Martin been at the hospital on this date? Yes, he had just come back. We wondered whether any diagnosis had been given or whether he had been told to come back? He was to go back to the Neurology Clinic the following day. From Mrs. Martin's strained expression, we thought that she knew more. We asked if she had been given any diagnosis. Perhaps it would be better if she could tell us what she had

[1] We had previously learned the diagnosis from the social worker at the clinic to which we had referred Mr. Martin and had at that time been told that Mrs. Martin should come in for a Wassermann test.

been told. With a burst of feeling Mrs. Martin said that he had been told that there was a strain of syphilis in his blood. He had just come home and told her. Neither of them had dreamt that it was possible. Mr. Martin had said that he hardly knew whether he dared to tell her. We asked how she felt about it. She replied with feeling that she could not believe it. She burst into tears and cried for several minutes. Again she said that it was the last thing she had dreamt possible and that she still could not believe that it was true.

She began to bring out a great deal of anger against us, speaking with feeling. She shouldn't ever have said anything about Mr. Martin to us. She had felt terrible ever since she talked with us the previous week. It was not true that Mr. Martin had been strange before this last year; none of the things she had said about him were true. They had never had any quarrels to compare with other people's. She had lived in two-family houses so she knew how some people fought. Mr. Martin had never been anything but good to her. Oh, they had had little differences, but none to compare with other people's. What she had said about his threatening suicide was not really true. She should never have said that. She was crying quite hard at this point. Through her sobs she said that it was really she who thought of suicide. She cried harder than ever and became more openly aggressive toward us. She should never have said anything against Mr. Martin. She would not have, except for us. We just made her think that he was worse than he really was and that led her to imagine these things. Every time she came to see us, she felt terrible afterward. She had cried almost all the time since she came in to see us the previous week.

We commented that she was feeling guilty for talking to us about Mr. Martin when he was so ill, that she felt angry at us because we had gotten her to talk about him. Mrs. Martin denied this violently. She did not feel guilty. She knew that it was her fault, not ours, that she had talked about him. Again with feeling she told us that nothing she had told us about him was true. He was not losing his mind. She had always known that there was just something physically wrong. Even the statement he had made to his employer that he had three testicles had not been strange since he actually had a tumor which would give this impression. That did not mean that there was anything wrong with him. We commented quietly that she had told us this once before and that we could understand how he might get this idea. Mrs. Martin spoke again of how terrible some of her neighbors in two-family houses were in comparison to Mr. Martin. They quarreled so everyone could hear. There had been nothing like that between Mr. Martin and her. On the whole he had been good to her. She had no cause to complain. She did not know why she had said these things to us. With a rising inflection of anger in her voice, she said again that it was we who made her think of all the little difficulties that never really amounted to anything. She should never have said anything against Mr. Martin to us. Their little differences were really of no importance. Her voice and expression were pleading at this point.

Once more we commented that we thought she was feeling guilty for talking about Mr. Martin to us. Probably she felt that it was disloyal when he was so ill. Sobbing, she said again that she should never have said any of these things abou Mr. Martin to us. We commented that we though she was afraid that she had given us the wron impression, that we might think her disloya Perhaps she was worried, too, lest Mr. Marti know that she had talked to us about him. Wit a note of fear in her voice, she said that he di not know anything she had said . . . at least, sh hoped not. She did not tell him. She looked a us questioningly. We said that of course we con sidered what she told us confidential and woul not be repeating it either. She looked reassured We went on to suggest that we did not think sh need be concerned lest we have the impressio from what she had told us that she found onl fault with Mr. Martin. She suggested rathe eagerly that everyone had some faults but tha Mr. Martin's were really insignificant. W agreed that there was good and bad in everyon and remarked that this would be true of Mr Martin. We went on to suggest that we though she had at least two feelings regarding him: ther were times at which she was very conscious of hi bad qualities and the things about him whic annoyed her; there were other times at which sh saw chiefly the good things about him which sh liked. She had been recalling chiefly his irritatin and annoying qualities in talking with us thes past weeks, but of course we had known that thi was only the part of the picture most on her min at the time. It was natural that she should fee guilty now and be angry at us for having encour aged her to recall these things. It was all right We thought she looked relieved. She replie apologetically that she should not blame us; sh knew it was hard for us to talk to people. W said, "It is hard for you to talk to people." Sh made no response to this.

Once more she went over how we made he recall all the difficulties regarding Mr. Martin b giving her the impression that we thought he wa losing his mind and that nothing could be done fo him. We made her think of little things in th past which seemed strange but it was not true tha he had been losing his mind or that he had bee strange a long time ago. She had never believe this. Her voice and manner were very pleadin again. She had always known that there wa something physically wrong rather than that h was losing his mind. We remarked that we won dered what she had thought when she told us tha she believed he had softening of the brain a few weeks ago, later that she thought it might b dementia precox, and last week that it seemed lik locomotor ataxia. Had she not been afraid her self that his mind was affected? Perhaps she ha guessed what was wrong. She assured us that she had never really thought that he was losing his mind or guessed what was wrong. It was just because we gave her the impression that we thought that he was losing his mind that she had asked. She did not really know why she had mentioned softening of the brain or dementia precox. She had read up on locomotor ataxia in a book she had at home and noted that some of Mr. Martin's movements were disturbed, so she asked about this. She had not really believed it was that herself.

We suggested that she might have been trying to find out what we thought. Probably she felt that we had been "holding out" on her. Perhaps she felt that we had known what was wrong with Mr. Martin all along and had not told her. This

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1525	9 inches	6 inches	½ inch
1526	9¾ "	7⅛ "	"
1527	10½ "	7⅜ "	"
1530	12 "	9⅛ "	"

Other sizes made to order

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